BUCK V. BELL AND BEYOND: A REVISED STANDARD TO EVALUATE THE BEST INTERESTS OF THE MENTALLY DISABLED IN THE STERILIZATION CONTEXT

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Although the general right to privacy is well settled in constitutional jurisprudence, the contours of the right to privacy are ever-changing. Maura McIntyre delves into one of the more contentious offshoots of the right to privacy—sterilization of the mentally disabled. For over a century, courts have granted petitions for sterilization of the mentally disabled. As the eugenics movement faded, however, new rationales for sterilization arose. More concerned with the individual rights of the mentally disabled, modern courts have applied various standards to evaluate petitions for sterilization.

Unfortunately, a reliable judicial approach to petitions for sterilization is still lacking. Consequently, the results across the country have been inconsistent and, in many cases, unjust. McIntyre analyzes the various approaches that courts have taken to evaluate petitions for sterilization. Considering the ramifications of each approach, McIntyre recommends a "revised best interest" inquiry to best assure the protection of the mentally disabled. In the end, the recommendation seeks to bring justice and consistency to this overlooked, yet important, area of law.

I. INTRODUCTION

At seven years old, Kirsten Johnson, a vibrant and mentally sound girl, was hit by a car.[1] Although Ms. Johnson survived, she sustained a traumatic brain injury that would compromise her ability to handle her own affairs into adulthood.[2] Now, at the age of twenty-six, she struggles to perform many household chores that most take for granted, such as operating a microwave or stove.[3] Her memory and concentration skills, as well as her ability to appreciate the nuances of various social situa-

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1. Michael J. Higgins, *Guardian Sues to Sterilize Her Niece: A Mentally Disabled 26-Year-Old Wins Stay on Forced Surgery*, CHI. TRIB., Aug. 12, 2005, at 1.

2. *Id.*

3. *Id.*

tions, are severely impaired.[4] In spite of such cognitive deficiencies, she attended high school, held a job as a paid employee, and currently participates in various workshops and programs with other similarly disabled individuals.[5]

Finally, Ms. Johnson has become sexually active.[6] This activity raises a number of concerns. What if she becomes pregnant? Can she handle the stress of pregnancy? Can she adequately care for a child? If not, who will care for the child? Will she be able to cope with the trauma of giving the child up for adoption?

With these concerns in mind, Ms. Johnson's guardian filed a petition in the Probate Division of the Circuit Court of Cook County, Illinois requesting authorization to consent to a tubal ligation.[7] Unfortunately, the judge in this case was left with little, if any, precedent in Illinois to guide his decision.[8] However, the U.S. Supreme Court recognizes "that a right of personal privacy . . . exist[s] under the Constitution. . . . [While] it [is] clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' are included in this guarantee . . . . the right has some extension to . . . procreation."[9] Many state courts permit the sterilization of mentally disabled individuals, even in the absence of legislation specifically authorizing them to do so, if they find that the procedure is in the best interest of those individuals.[10] Most courts consider upwards of nine factors to determine whether sterilization is in the individual's best interest.[11] Unfortunately, courts have such great latitude in making their ultimate decision[12] that it is unclear whether the inquiry ends in a proper result.

This note analyzes the legal precedent and policy concerns surrounding petitions for the sterilization of mentally disabled women.[13] Part II defines the scope of the individual's fundamental right to privacy, sketches the history of the sterilization of persons with mental disabilities from the early twentieth century to the present, and explains the various approaches that states take to determine whether such petitions should be granted. Part III provides a detailed illustration of three legal rules guiding decision makers in the thirty-two states that currently do not

4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. Estate of Johnson, No. 96 P 11118, slip op. at 1 (Ill. Cir. Ct. Aug. 11, 2005).
9. Roe v. Wade, 410 U.S. 113, 152 (1973) (citations omitted).
10. Norman L. Cantor, *The Relation Between Autonomy-Based Rights and Profoundly Mentally Disabled Persons*, 13 ANNALS HEALTH L. 37, 38–39 (2004).
11. Estate of C.W., 640 A.2d 427, 428–29 (Pa. Super. Ct. 1994).
12. *Id.*
13. Although the issue of sterilization implicates the rights of both men and women, this note focuses solely on the rights of women. Determining whether to grant or deny petitions for the sterilization of mentally disabled women requires that courts consider certain factors, such as the physical and emotional effects of pregnancy and labor, that are irrelevant in determining whether to grant or deny petitions for the sterilization of mentally disabled men.

have statutes addressing the sterilization of mentally disabled individuals. Part III also examines the inconsistencies surrounding those rules, focusing specifically on the problems associated with the discretionary best interest standard that was utilized by the court in *Estate of Johnson*. Finally, Part IV introduces a simplified best interest inquiry that better guides courts in their decisions to grant or deny sterilization petitions. Part IV ultimately establishes that, by limiting the number of factors the court considers, this simplified inquiry also better protects the best interests of the individual in light of her specific situation.

II. BACKGROUND

"[E]very person has a right to be sterilized if he wishes to be and no person will be sterilized if he does not wish to be. Despite [one's] inability to exercise a free choice, [one] should be treated in a manner that does not deviate from these principles any more than the circumstances require."[14] Presuming the fundamental right to privacy exists, the right belongs to *every* citizen, regardless of his or her level of mental competency. In order to best understand the strong judicial presumptions against sterilization and the courts' general hesitation to grant sterilization petitions, one must understand the scope of the fundamental right to privacy, the history of the sterilization of mentally disabled individuals, and the different approaches that state legislatures have taken in granting or denying petitions for sterilization.

A. The Fundamental Right to Privacy for Mentally Disabled Individuals

The right to privacy was first recognized in 1891 in *Union Pacific Railway Co. v. Botsford*, where Justice Gray explained, "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others."[15] Further, the Supreme Court has stated that the "right [to privacy] includes the privilege of an individual to plan his own affairs, for, 'outside areas of plainly harmful conduct, every American is left to shape his own life as he thinks best, do what he pleases, go where he pleases.'"[16] Because that right is deemed fundamental, a state cannot constitutionally deprive an individual of it unless the state can demonstrate a compelling interest for doing so.[17] In addition, "the means by which the state promotes [that compelling] interest 'must be narrowly drawn to express only the legitimate state inter-

14. *In re* Grady, 426 A.2d 467, 481 n.9 (N.J. 1981).

15. 141 U.S. 250, 251 (1891).

16. Doe v. Bolton, 410 U.S. 179, 213 (1973) (quoting Kent v. Dulles, 357 U.S. 116, 126 (1958)).

17. Roberta Cepko, *Involuntary Sterilization of Mentally Disabled Women*, 8 BERKELEY WOMEN'S L.J. 122, 129–30 (1993).

ests at stake.'"[18] While the general right to privacy has been accepted for some time now, the scope of that right has undergone various changes. Currently, many courts differ in their approach to the fundamental rights issues at stake in petitions for sterilization.[19] Thus, a clear understanding of the scope of the right to privacy is imperative before one can improve or abandon the standards currently employed in the sterilization context.

1. The Scope of the Right to Privacy

A string of Supreme Court decisions in the 1960s and 1970s broadened the scope of the right to privacy guaranteed under the Fourteenth Amendment. In 1965, the Supreme Court held in *Griswold v. Connecticut* that a state statute prohibiting the use of contraceptives was unconstitutional because the statute intruded upon the right of marital privacy.[20] The court explained, "[s]uch a law cannot stand in light of the familiar principle, so often applied by this Court, that a 'governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.'"[21] Less than ten years later, in *Eisenstadt v. Baird*, the Supreme Court declared that a state statute permitting married persons to obtain contraceptives to prevent pregnancy, but prohibiting single persons from enjoying the same right, was unconstitutional. According to *Eisenstadt*, the right to privacy established in *Griswold* is guaranteed to individuals.[22] "[I]f the right to privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[23] In these cases, the Court effectively established that the Constitution guarantees a right to privacy in making decisions to procreate.

The Court further broadened the scope of this right in the controversial *Roe v. Wade* decision. There, the Court held that the concept of liberty guaranteed by the Fourteenth Amendment extends only to those rights that are "fundamental" or "implicit in the concept of ordered liberty."[24] Government regulation limiting such rights is justified only in light of a compelling state interest.[25] In the abortion context, the specific and direct harm that the woman may suffer if denied the choice to terminate a pregnancy is so great that it is unlikely that the state has any inter-

18. *Id.* (quoting Roe v. Wade, 410 U.S. 113, 155 (1973)).
19. *Id.* at 130–31.
20. Griswold v. Connecticut, 381 U.S. 479, 485 (1965).
21. *Id.* (quoting NAACP v. Alabama, 377 U.S. 288, 307 (1964)).
22. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("[T]he marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional makeup.").
23. *Id.*
24. Roe v. Wade, 410 U.S. 113, 152–53 (1973) (citations omitted).
25. *Id.* at 155.

est compelling enough to outweigh such harm.[26] While the Court refused to recognize an *unlimited* right to do with one's body as one pleases, it ultimately held "that the right of personal privacy includes the abortion decision."[27]

2. Historical Background of Sterilization of Persons with Mental Disabilities

Sterilization laws emerged in the early 1900s in response to both the development of the vasectomy for males and the tubal ligation for females and the rise of eugenics.[28] Studies conducted around the same time demonstrated that mental retardation was prevalent in some families.[29] Believing that "the feeble-minded" were responsible for many of society's ills, states began to pass laws authorizing the sterilization of such individuals.[30] In 1927, the constitutionality of these laws was challenged. The Supreme Court, in *Buck v. Bell*, ultimately held that such laws were constitutional.[31] In that case, the Court authorized the sterilization of a "feeble-minded" woman, whose mother and daughter were also "mentally defective," pursuant to a Virginia sterilization statute.[32] The Court explained that "[i]t is better for all the world . . . [if] society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes."[33] After *Buck v. Bell*, more states began to pass sterilization enabling statutes.[34]

In the middle of the twentieth century, however, states began repealing sterilization statutes similar to the one at issue in *Buck v. Bell*.[35]

26. *Id.* at 153 ("The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress . . . associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it.").

27. *Id.* at 154 (noting that "this right is not unqualified and must be considered against important state interests in regulation").

28. Karl A. Menniger, *Proof of Qualification for Sterilization of a Person with a Mental Disability*, *in* 49 AM. JUR. 3D *Proof of Facts* § 6 (2005).

29. *Id.*; *see also* Eric M. Jaegers, *Modern Judicial Treatment of Procreative Rights of Developmentally Disabled Persons: Equal Rights to Procreation and Sterilization*, 31 U. LOUISVILLE J. FAM. L. 947, 951 (1993) ("As one scholar suggests, the legislative response to [eugenics] was straightforward, quick and predictable: 'if retardation was inherited, a sterilization program limited to the relevant target groups would, over time, eliminate the problem of retardation.'" (citations omitted)).

30. Jaegers, *supra* note 29, at 951.

31. Buck v. Bell, 274 U.S. 200, 207 (1927).

32. *Id.* at 205.

33. *Id.* at 207.

34. Menniger, *supra* note 28, § 6; *see* Jill Alward, *Imbecile Offspring or Flourishing Family? A Call for Justice for the Mentally Retarded*, 7 QUINNIPIAC HEALTH L.J. 175, 177 (2003) ("By 1917, fifteen other states had similar statutes and by 1942 statutes existed in thirty-two states."); *see also* discussion *infra* Part II.B.

35. *See* Jaegers, *supra* note 29, at 959; Elizabeth S. Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 DUKE L.J. 806, 807.

Various circumstances accounted for this development. First, the term "sterilization" began to develop negative connotations. Much of this negativity arose in response to the Nazi party's abuse of sterilization procedures during World War II.[36] Second, the premises of the eugenics movement started to unravel.[37] Finally, many state institutions reduced the number of sterilization procedures performed on patients.

Changing attitudes continue to influence the increased protection of rights of mentally disabled individuals.[38] Today, mentally disabled people are "no longer viewed as helpless recipients of the state's benevolence, but as people who can and should be treated with dignity and who are presumed to be competent to make decisions for themselves unless proven otherwise."[39] They may be expected to engage in sexual activities, particularly if they reside in the community and seek to live a normal, noninstitutionalized life.[40]

3. Mentally Disabled Individuals' Exercise of the Right to Privacy

Unfortunately, because of their cognitive limitations, mentally disabled individuals cannot consent to sterilization, a right they are afforded under the constitutional right to privacy.[41] In states where sterilization enabling statutes were repealed, those petitioning courts for the authorization of sterilization began to bear the heavy burden of proving that performance of such a procedure on the mentally disabled was justified.[42] Despite the changing attitudes discussed previously, the general position regarding mentally disabled individuals' right to privacy remains profoundly conflicted:

> [A]mbivalence toward mentally disabled citizens who are sexually active still lingers. Group homes are filled with Robbies, Timmies, and Beckies with childhood nicknames they never outgrow . . . . We are easily unnerved when cognitively disabled adults fail to act out the role of the cute and docile children we have reserved for them . . . . [However, it] is impossible to shield people with cognitive disabilit[ies] from their central life reality. Infantilization of the cognitively disabled is especially destructive in delicate arenas of sexuality . . . . They have adult hormones, a lifetime of memories and relationships with others. They are not children.[43]

36. Jaegers, *supra* note 29, at 955; Scott, *supra* note 35, at 811.

37. Jaegers, *supra* note 29, at 954–55 ("First, as scientific understanding of mental retardation became more sophisticated, researchers were able to disprove or discredit many premises upon which eugenics was based. . . . Further, evidence surfaced indicating that the majority of inheritable mental deficiencies are transmitted by parents who are considered normal." (citations omitted)).

38. *Id.* at 958–59.

39. *Id.*; *see* Menniger, *supra* note 28, § 7.

40. *See* Menniger, *supra* note 28, § 7.

41. *Id.*; *see* discussion *infra* Part II.A.3.

42. Menniger, *supra* note 28, §§ 13–15.

43. Harold Pollack, *The Parent Trap: Birth Control and the Developmentally Disabled*, CHI. TRIB., Aug. 18, 2005, at C23.

Although many people still struggle to accept that mentally disabled individuals engage in sexual activity, at least one commentator urges us "to recognize that, as human beings, mentally disabled persons are entitled to develop, express, and enjoy their sexuality to the same extent as anyone else."[44] Inherent in that recognition is the understanding that mentally disabled individuals should be afforded the same opportunity to exercise their right to procreate that mentally competent individuals are currently afforded.[45]

The Supreme Court has recognized that the constitutional right to privacy encompasses the right to choose for one's self whether to procreate.[46] As some scholars have pointed out, "the right not to procreate and the right to procreate are equal components of a larger right of procreative choice."[47] This right belongs to all citizens—regardless of one's level of mental competency.[48] Whether courts conduct only a cursory analysis of the fundamental right to privacy or hold that there is no state interest compelling enough to justify involuntary sterilization,[49] it is apparent that, at the very least, courts recognize and acknowledge that the right to privacy cannot be ignored in the sterilization context.

B. Enabling Statutes

Currently eighteen states have statutes that authorize court-ordered sterilizations of mentally disabled individuals.[50] Each statute differs to some degree. For instance, some apply only to those unable to give consent, while some apply only to those who are "mentally retarded," "mentally ill," "brain damaged," "developmentally disabled," or "residents of state facilities for the mentally ill."[51] Also, some state statutes require that the individual be capable of giving informed consent to the procedure before the court may grant the petition, yet other statutes require an inquiry into the individual's best interest in the event that the individual is incapable of consenting to sterilization procedures.[52]

Above all, the reasoning behind and employment of standards for evaluating sterilization petitions varies considerably from state to state.

44. Robert Randal Adler, Estate of C.W.: *A Pragmatic Approach to the Involuntary Sterilization of the Mentally Disabled*, 20 NOVA L. REV. 1323, 1362 (1996) (citing George W. Lee, *The Sexual Rights of the Retarded—An International Point of View*, *in* SEXUAL RIGHTS AND RESPONSIBILITIES OF THE MENTALLY RETARDED 58 (Medora S. Bass et al. eds., 1973) (quoting Dr. J. M. Kahn from the August 1972 issue of the *British Medical Journal*)).

45. Jaegers, *supra* note 29, at 977.

46. Estate of C.W., 640 A.2d 427, 441 (Pa. Super. Ct. 1994) (Johnson, J., dissenting).

47. Jaegers, *supra* note 29, at 977.

48. *Estate of C.W.*, 640 A.2d at 441 (Johnson, J., dissenting).

49. Cepko, *supra* note 17, at 130–31.

50. Menniger, *supra* note 28, § 8.

51. *Id.*

52. *Id.* § 9.

While some states still employ a eugenic rationale,[53] most focus on the woman's ability to adequately care for a child or on the potential physical and psychological effects that procreation may have on her.[54] Although most states consider the same factors in their analyses, their application of the factors differs. Some states require that each factor is proven while others require that each factor is merely weighed.[55] Regardless of these differences, the specific criteria and procedural provisions were intended to offer some degree of protection to individuals with disabilities.[56] Effectively, specific factors and procedural safeguards have been included in most enabling statutes to guarantee that persons with mental disabilities are not sterilized solely to prevent the birth of another mentally disabled individual (as was the rationale in *Buck v. Bell*) or to convenience others (such as the individual's parent or legal guardian).[57]

C. Common Law in Absence of Enabling Statutes

In those states that do not have enabling statutes, the determination of whether courts have the authority to permit parents or legal guardians of incompetent minors or adults to consent to sterilization has triggered a split in authority.[58] Although some courts hold "that they lack jurisdiction to approve it, . . . others have concluded that they may approve sterilization where there is no legislative authorization."[59] In *Stump v. Sparkman*, a woman who had been sterilized by order of the Indiana circuit court brought suit against the judge who granted the petition for sterilization, claiming that he failed to comply with the principles of procedural due process.[60] The Indiana statutes at issue provided for the sterilization of institutionalized persons under some circumstances, but they did not contain any express authority for judicial approval of tubal ligations.[61] The U.S. Supreme Court explained:

> [I]t is more significant that there was no Indiana statute and no case law in 1971 prohibiting a circuit court, a court of general jurisdiction, from considering a petition of the type presented to Judge Stump. The statutory authority for the sterilization of institutionalized persons in the custody of the State does not warrant the inference that a court of general jurisdiction has no power to act on a pe-

53. *Id.* § 12; *see also* Scott, *supra* note 35, at 809–10 ("[E]ugenic theory . . . posited that intelligence and most personality traits are genetically based and are predictably inherited by children from their parents. The objective of the eugenic sterilization laws was to protect and improve society by preventing reproduction by those who might produce defective offspring.").

54. Menniger, *supra* note 28, § 12.

55. *Id.*

56. *Id.*

57. *Id.*

58. LAWRENCE A. FROLIK & MELISSA C. BROWN, ADVISING THE ELDERLY OR DISABLED CLIENT ¶ 19.06(4) (2006).

59. *Id.*

60. Stump v. Sparkman, 435 U.S. 349, 353 (1978).

61. *Id.* at 358.

> tition for sterilization of a minor in the custody of her parents, particularly where the parents have authority under the Indiana statutes to [consent to medical treatment of the minor].[62]

In cases where the liberty of an individual is at issue and there is a great conflict as to which law should ultimately govern the decision, the judge bears a great responsibility.[63] Respecting such responsibility, where the judge has jurisdiction to grant the petition, the judge is immune from suit, even if he approved the petition in error.[64]

State courts holding that they have jurisdiction (in the absence of appropriate legislation) to grant petitions for sterilization often consider factors similar to those enumerated in enabling statutes. As in those states with enabling statutes, states without enabling statutes also differ as to whether they require that a certain number of factors be proven or whether they require that the factors be weighed appropriately.[65] As of late, courts "have framed the issue [of sterilization] in terms of protecting the person's right to procreate and some courts presume that sterilization is not in the person's best interest."[66] The burden rests with the petitioner to prove that sterilization is in the best interest of the individual and that the reasons for sterilization are adequately supported by expert opinion.[67] Given that the standards vary greatly in degree and application, it is unclear whether they sufficiently protect the privacy interest at stake and produce proper results.

III. ANALYSIS

Currently, courts adopt one of three rules[68] to determine whether to grant a petition for sterilization of any individual deemed incompetent for the purpose of giving informed consent to the procedure:[69] (i) the substituted judgment standard,[70] (ii) the minority criteria rule,[71] or (iii)

62. *Id.*
63. *Id.* at 364.
64. *Id.*
65. Menniger, *supra* note 28, § 15.
66. *Id.*
67. *Id.*
68. Here, the goal is to create a standard in those jurisdictions willing to consider petitions for sterilization; thus, this note will not analyze the fourth rule, which prohibits the sterilization of any individual deemed incompetent for the purpose of giving informed consent to the procedure. *See* Scott, *supra* note 35, at 823 (citing COLO. REV. STAT. § 27-10.5-128(2) (Supp. 1985) ("No person with developmental disabilities who has not given consent shall be sterilized.")).
69. Eric M. Jaegers identifies five general categories. *See* Jaegers, *supra* note 29, at 956–66. He includes a "medically essential" rule, currently applied by a few states, "under which a court can authorize sterilization if it is clearly necessary to preserve the life or physical or mental health of the individual." *Id.* Because the analysis in this article focuses on otherwise healthy mentally disabled women, there is no need to discuss this fifth category.
70. *See* discussion *infra* Part III.A. *See generally In re* Grady, 405 A.2d 851 (N.J. Super. Ct. Ch. Div. 1979).
71. *See* discussion *infra* Part III.B. *See generally In re* Hayes, 608 P.2d 635 (Wash. 1980).

the discretionary best interest standard.[72] While the first three rules seem to promote different objectives, whether to protect the individual's right to procreate or to approximate the decision the individual would make if competent to do so, each strives to protect the interests of the mentally disabled by imposing a heavy presumption against sterilization and by requiring court approval.[73] Unfortunately, these rules were created as a result of state courts selectively adopting the case law of other similarly situated states.[74] This practice has resulted in the evolution of standards with conflicting and unpredictable outcomes. Even the most commonly employed standard, the discretionary best interest standard, does not necessarily produce the proper result.[75]

The substituted judgment standard, the mandatory criteria rule, and the discretionary best interest standard each have their own merits and demerits. In order to create a revised standard that will better guarantee the proper result, it is necessary to understand the intricacies of each standard and, especially with respect to the discretionary best interest standard, the inconsistent manner in which these standards have been applied.

A. The Substituted Judgment Standard

"The objective of the substituted judgment approach is for the decision-maker to 'step into the shoes' of the incompetent in order to make a decision that subjectively reflects what the individual's values and preferences would be were she competent."[76] This test is commonly applied in cases involving once competent individuals who expressed a desire to undergo or not to undergo a specific medical procedure while still competent.[77] However, some courts have applied it in cases involving never-competent individuals.[78]

In *In re Grady*, the parents of an eighteen-year-old woman suffering from Down's Syndrome petitioned the court for approval of a tubal ligation after Morristown Memorial Hospital refused to perform the proce-

72. *See* discussion *infra* Part III.C.1–2. *See generally In re* Terwilliger, 450 A.2d 1376, 1383 (Pa. Super. Ct. 1982).

73. Scott, *supra* note 35, at 823–24.

74. Lisa Barton, *Mental Health—Pennsylvania Superior Court Affirms Authorization to Sterilize Mentally Handicapped Women—*Estate of C.W.*, 640 A.2d 427 (Pa. Super. Ct. 1994),* Cert. Denied*, 115 S. Ct. 1175 (1995)*, 68 TEMP. L. REV. 1009, 1028 (1995).

75. *Id.*

76. *See* Scott, *supra* note 35, at 823–24; *see also* Steven J. Cleveland, *Sterilization of the Mentally Disabled: Applying Error Cost Analysis to the "Best Interest" Inquiry*, 86 GEO. L.J. 137, 141–42 (1997).

77. Adler, *supra* note 44, at 1344.

78. *In re* Moe, 432 N.E.2d 712, 719 (Mass. 1982). *In re Moe* held that

> in the absence of legislation, a court may exercise the doctrine of substituted judgment, thus avoiding the question of government interference with a fundamental right. The Moe court accepted the fiction of substituted judgment, which purports to determine what the incompetent person's intent would be if competent, and rejected the imposition of a high standard of proof in sterilization petitions.

Barton, *supra* note 74, at 1017 n.57.

dure without court authorization.[79] Recognizing the conflict between the right to be free from involuntary sterilization and the right to obtain sterilization, the judge ultimately concluded that the intuitive feeling of the young woman's parents served as the best indicator of her subjective values and preferences.[80] Justifying his decision, the judge explained that it was for the woman's parents, and not the court, to make the decision to undergo a sterilization procedure in accordance with what they believed she would decide for herself if capable of making an informed decision.[81] On appeal, the Supreme Court of New Jersey rejected the substituted judgment standard employed by the lower court. The court outlined rigid substantive and procedural safeguards that needed to be met before substituted judgment could be exercised.[82] By providing these safeguards, the court aimed to protect those who were otherwise unable to help themselves.[83]

Proponents of the substituted judgment standard argue in favor of its application in all cases involving petitions for sterilization. They contend that, even if "'an individual would, if competent, make an unwise or foolish decision, the judge must respect that decision as long as he would accept (or be bound to accept) the same decision if made by a competent individual in the same circumstances.'"[84] This standard allows mentally disabled individuals to exercise their rights in spite of their mental limitations by focusing on the decision they *would* make rather than the one they *should* make.[85] In effect, it allows mentally disabled individuals to enjoy common entitlements unhindered by their limitations.[86] Proponents believe that this standard renders a decision more consistent with the particular individual's wishes than the other tests.[87]

Unfortunately, the substituted judgment standard cannot ensure that the decision rendered is the same decision that the incompetent individual would make. This inescapable limitation of the substituted judgment standard creates several difficulties. First, in some circumstances, "[t]he application of the substituted judgment approach is problematic because it requires the surrogate decision maker to discern the competent values and preferences of a never competent person."[88] There is no guarantee that the surrogate decision maker has not, at the very least, interjected her own values or preferences in rendering her ultimate decision. Opponents of this standard have pointed out that such interjections often occur when the interests of the third party and the in-

79. *In re* Grady, 405 A.2d 851 (N.J. Super. Ct. Ch. Div. 1979).
80. *Id.* at 865–66.
81. *Id.*
82. *In re* Grady, 426 A.2d 467, 486 (N.J. 1981).
83. *Id.*
84. *In re* Moe, 432 N.E.2d 712, 720 (Mass. 1982) (citation omitted).
85. *Id.*
86. *In re* Grady, 405 A.2d at 866.
87. Adler, *supra* note 44, at 1344.
88. Scott, *supra* note 35, at 823 n.56.

capacitated individual conflict.[89] For example, a family's desire to sterilize an incompetent family member to avoid the burden of supervising the individual's sexual activity may detract from the focus on the individual's right to choose.[90] As currently applied, the substituted judgment standard does not have any procedural safeguards in place to prevent such problems.

Secondly, even in the context of once-competent individuals, there is a strong argument that the individual's preference may change. "Even if the incompetent individual had made her subjective feelings clear before becoming incompetent, the validity of those clear feelings may have been lost due to the significant passage of time between her expressions and the time of the sterilization decision."[91] Many young girls dream of becoming a mother at the age of seven, but eventually opt not to have children for a wide variety of reasons. The more time that passes between the expression of those subjective feelings and the need to make a substituted decision, the more difficult it becomes for a surrogate decision maker to effectively step into the incompetent individual's shoes and make the decision that she would have made for herself.[92]

Finally, there is a strong argument that, in the case of never-competent individuals, courts only nominally apply the substituted judgment standard and ultimately render a decision based on the individual's best interest.[93] This melding of the substituted judgment and best interest standards has occurred in many cases in medical contexts other than sterilization,[94] but could just as easily occur in the sterilization context. Based on the arguments articulated by its opponents, the substituted judgment standard alone seems inappropriate in the context of the sterilization of mentally disabled adults; however, it is still not clear that other alternatives currently employed are any better.

B. The Mandatory Criteria Rule

The Supreme Court of Washington was one of the first courts to employ what was once the most common standard used to determine whether to grant a sterilization petition: the mandatory criteria rule.[95] The rule essentially requires the judge to find, by clear, cogent, and convincing evidence, that: (1) the individual lacks the competency required to make her own decision regarding sterilization; (2) there is a need for contraception;[96] and (3) there are no alternatives to the sterilization pro-

89. Norman L. Cantor, *The Bane of Surrogate Decision-Making: Defining the Best Interests of Never-Competent Persons*, 26 J. LEGAL MED. 155, 197 (2005).

90. *Id.* at 192–93.

91. Cleveland, *supra* note 76, at 140–41.

92. *Id.*

93. Cantor, *supra* note 89, at 159.

94. *Id.* at 160.

95. Jaegers, *supra* note 29, at 965.

96. To make such determination, the judge must

cedure.[97] Courts adopting the mandatory criteria rule may grant a petition for sterilization only if each of these criteria is clearly met.[98] The standard is rigid, and the burden is great.[99]

As in *Grady*, in *In re Hayes* the mother of a mentally disabled minor filed a petition to have the minor sterilized. The Supreme Court of Washington, however, rejected the substituted judgment standard promoted by the Superior Court of New Jersey, explaining that the right of privacy belongs to the cognitively disabled individual.[100] Although parents may be entitled to advise or participate in their child's decision regarding sterilization, "that decision belongs to the child, not to his parents."[101] Ultimately, the court in *Hayes* applied the mandatory criteria rule and denied the mother's petition for the sterilization of her mentally disabled minor child, holding that the petitioner failed to establish any of the criteria by clear, cogent, and convincing evidence.[102] The medical testimony failed to prove that the minor would not have been able to understand or control her sexual activity in the future.[103] In addition, although the petitioner demonstrated that *some* methods of birth control had already been tried, the court did not feel that such evidence was sufficient to prove that no conventional forms of contraception could serve as a reasonable alternative to sterilization.[104]

Proponents of the mandatory criteria rule argue that such a stringent standard best protects the privacy interest of the mentally disabled individual by properly restricting the discretion of the judge.[105] The elevated burden of proof placed on the petitioner (clear, cogent, and convincing) coupled with the clearly articulated *specific* factual findings required to grant a petition for sterilization leave little room for judicial discretion.[106] In addition, proponents contend, "[a]s a legal decision prin-

find that the individual is (1) physically capable of procreation, and (2) likely to engage in sexual activity at the present or in the near future under circumstances likely to result in pregnancy, and must find in addition that (3) the nature and extent of the individual's disability, as determined by empirical evidence and not solely on the basis of standardized tests, renders him or her permanently incapable of caring for a child, even with reasonable assistance.

In re Hayes, 608 P.2d 635, 641 (Wash. 1980).

97. To make such determination, the judge must

find that by clear, cogent and convincing evidence (1) all less drastic contraceptive methods, including supervision, education and training, have been proved unworkable or inapplicable, and (2) the proposed method of sterilization entails the least invasion of the body of the individual. In addition, it must be shown by clear, cogent and convincing evidence that (3) the current state of scientific and medical knowledge does not suggest either (a) that a reversible procedure or other less drastic contraceptive method will shortly be available, or (b) that science is on the threshold of an advance in the treatment of the individual's disability.

Id. 608 P.2d at 641.

98. Jaegers, *supra* note 29, at 965.

99. *Id.*

100. *Hayes*, 608 P.2d at 639 (citing Eisenstadt v. Baird, 405 U.S. 438, 453 (1972)).

101. *In re* Grady, 426 A.2d 467, 482 (N.J. 1981).

102. *Hayes*, 608 P.2d at 641.

103. *Id.* at 642.

104. *Id.*

105. Scott, *supra* note 35, at 822.

106. *Id*. at 822 n.53.

ciple, [the mandatory criteria rule] may be easier to apply than the discretionary best interest standard . . . because it incorporates fewer factual variables."[107] Finally, proponents of this rule have suggested that it corrects the many previous abuses of sterilization.[108]

In the final analysis, however, these arguments are unconvincing. First, the heavy burden placed on the petitioner under the mandatory criteria rule "overvalues" the individual's right to procreate.[109] In *Hayes*, the court explained that it "must exercise care to protect the individual's right of privacy, and thereby not unnecessarily invade that right."[110] In practice, however, the mandatory criteria rule, originally designed to protect an individual's fundamental right to privacy and built on the assumption that every mentally disabled individual has an interest in procreation, impairs the right *not* to procreate inherent in the fundamental right to privacy.[111] In other words, the mandatory criteria rule serves to protect the right to procreate at the expense of the equally significant right *not* to procreate.[112]

Secondly, by imposing such a stringent standard, the mandatory criteria rule permits courts to deny petitions for sterilization without closely examining the facts and interests specific to the particular mentally disabled individual.[113] There are many factors and variables that should be considered, even if only to a slight degree, to determine whether sterilization is appropriate in a particular context, such as the trauma the individual will suffer if she were to become pregnant. Thus, some critics of the mandatory criteria rule contend that, as currently applied, it does not necessarily yield proper results; the decision rendered may not benefit the particular individual for whom the procedure is proposed.[114]

Finally, opponents of this rule may argue that it makes sterilization seem so undesirable that courts are likely to deny petitions for sterilization even in situations where the procedure should be performed. Though many opponents applaud courts' desire to correct abuses of the past, they fear that pursuing this goal with such a rigid standard will lead to other problems in the future.[115] Given these concerns, many courts applying the mandatory criteria rule have manipulated its components in order to reach a particular result. Unfortunately, as the next section will demonstrate, the struggle to yield the proper result, given a specific set of circumstances, continues to date.

107. *Id.*
108. *Id.* at 846.
109. *Id.* at 847 (stating that standards such as the mandatory criteria rule "treat sterilization as an infringement of the right to procreate rather than as a means of exercising the right not to procreate").
110. *In re* Hayes, 608 P.2d 635, 640 (Wash. 1980).
111. Scott, *supra* note 35, at 847.
112. *Id.*
113. *Id.*
114. *Id.* at 822 n.53.
115. *Id.* at 865.

C. The Discretionary Best Interest Standard

The discretionary best interest standard offers the most flexible analysis. Rather than requiring specific findings, this standard directs judges to consider certain criteria in order to determine whether sterilization is in the mentally disabled individual's best interest.[116] This standard evolved as state courts began to alter the *Hayes* requirements, adding some factors and ignoring others as they saw fit.[117] The most commonly cited case in this arena, *In re Terwilliger*, set forth a nonexclusive list of factors to guide courts in their decision.[118] Unfortunately, the great discretion granted to courts under *Terwilliger* raises concerns as to whether the discretionary best interest standard actually leads to proper and consistent results.[119] Some state courts have interpreted *Terwilliger* as requiring that certain factors be weighed while other courts have interpreted it as requiring that certain factors be specifically met before granting petitions for sterilization.[120] Close examination of both interpretations of this standard, in light of the guidance provided by *Terwilliger*, illustrates the validity of these concerns.

1. The Terwilliger *Decision*

In *Terwilliger*, the parents of a twenty-five-year-old mentally disabled woman petitioned the court to authorize her sterilization.[121] After establishing that it had jurisdiction to grant the petition, the Pennsylvania Superior Court set forth a number of procedural safeguards and considerations to guide its decision. First, after a petition for sterilization has been filed, the court must appoint an independent guardian ad litem, who shall "meet with the ward, present evidence and cross-examine witnesses at the hearing."[122] Second, the mentally disabled adult must undergo "a comprehensive medical, psychological and social evaluation."[123] Third, the presiding judge must meet with the mentally disabled person to formulate her own impressions as to that person's level of compe-

116. *Id.* at 847.

117. Barton, *supra* note 74, at 1018.

118. *Id.* at 1009 ("[B]ecause the list of guidelines expressed in *Terwilliger* is not exhaustive, and pertinent facts often vary widely from case to case, Pennsylvania courts have enjoyed great latitude in applying the *Terwilliger* guidelines.").

119. Cleveland, *supra* note 76, at 142 ("A court's discretionary consideration and weighing of factors yields an inexact inquiry, so that a best interest standard 'defie[s] precise definition.'" (quoting *Development in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1596 (1990))); *see* Barton, *supra* note 74, at 1009 ("The lack of mandatory statutory guidelines, coupled with the Pennsylvania Superior Court's and Supreme Court of Pennsylvania's failure to apply the *Terwilliger* guidelines consistently, creates the potential for individual judges to alter the applicable test significantly.").

120. *See* discussion *infra* Part III.C.2.a–b.

121. *In re* Terwilliger, 450 A.2d 1376, 1378 (Pa. Super. Ct. 1982).

122. *Id.* at 1383.

123. *Id.*

tence. Based on this meeting, the judge will determine whether the mentally disabled individual should be present during the proceedings.[124]

After providing the safeguards enumerated above, the court must make a number of findings, similar to those required under the mandatory criteria rule, before delving into the factors provided in the "best interest" inquiry. First, the judge must find that "the individual lacks capacity to make a decision about sterilization and that the incapacity is not likely to change in the foreseeable future."[125] Second, the mentally disabled individual must be able to reproduce.[126] Third, the court must find that sterilization is the only sensible means of contraception.[127]

After highlighting the procedural safeguards and establishing the required findings, the Pennsylvania Superior Court provided a nonexclusive list of factors to guide its determination as to whether a petitioner has proven, by clear and convincing evidence, that sterilization is in the individual's best interest. The factors enumerated include: (1) the possibility that the incompetent person can become pregnant; (2) the possibility that the incompetent person will experience trauma or psychological damage if she becomes pregnant or gives birth, and, conversely, the possibility of trauma or psychological damage from the sterilization operation; (3) the likelihood that the individual will voluntarily engage in sexual activity or be exposed to situations where sexual intercourse is imposed upon her; (4) the inability of the incompetent person to understand reproduction or contraception and the likely permanence of that inability; (5) the feasibility and medical advisability of less drastic means of contraception, both at the present time and under foreseeable future circumstances;[128] (6) the advisability of sterilization at the time of the ap-

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* (explaining that the judge must find that "all less drastic contraceptive methods, including supervision, education and training are unworkable and detailed medical testimony must show that the sterilization procedure requested is the least significant intrusion necessary to protect the interests of the individual").

128. Currently, four general categories of birth control methods are available on the market: (1) barrier methods, which include interuterine devices (IUDs) and diaphragms; (2) hormonal treatments, such as Depro-Provera; (3) birth control pills or birth control patches; and (4) permanent methods such as tubal ligations and hysterectomies. There are many pros and cons to each of these methods, and, thus, the appropriateness, effectiveness, and invasiveness of each must be determined on a case by case basis. For example, barrier methods are not appropriate in situations where individuals lack the capacity to take responsibility for their own contraception. Similarly, birth control pills may not be appropriate in certain instances because of the high risk of a wide range of side effects. *See* Estate of C.W., 640 A.2d 427, 438 (Pa. Super. Ct. 1994) ("The birth control pill can cause side effects in any woman. Some of these may indicate that more serious problems, like thromboembolic disease, are developing.").

Sterilization procedures for women include: hysterectomies in which the uterus is removed, oophorectomies in which the Fallopian tubes and ovaries are removed, and tubal ligations in which the fallopian tubes are blocked. Currently, tubal occulation is the most frequently employed method of sterilization. However, mechanical methods are also performed that require the insertion of rings, plugs or clips to block the tubes. *See* Menniger, *supra* note 28, § 4.

plication rather than in the future; (7) the ability of the incompetent person to care for a child, or the possibility that the incompetent may at some future date be able to marry and, with a spouse, care for a child; (8) evidence that scientific or medical advances may occur within the foreseeable future that will make possible either improvement of the individual's condition or alternative and less drastic sterilization procedures; (9) a demonstration that the proponents of sterilization are seeking it in good faith and that their primary concern is for the best interest of the incompetent person rather than their own or the public's convenience.[129] The court in *Terwilliger* was careful to note that the factors "constitute . . . the minimal requirements that need to be examined to protect the constitutional rights of the incompetent. The need for additional inquiries and the weight to be given to each factor will vary with the particular facts and circumstances of each case."[130] Ultimately, the court intended for these factors to serve as a nonexclusive list that may be amended as facts or circumstances specific to a particular individual dictate.[131]

2. *Two Approaches to the Application of* Terwilliger*'s Best Interest Standard*

Proponents of the best interest inquiry, as applied in *Terwilliger*, contend that, if applied rigorously, it results in a fair evaluation of the individual's best interests and properly protects the individual's constitutional right of privacy.[132] Unfortunately, by providing such tremendous latitude, the *Terwilliger* decision opened the door to a great deal of judicial manipulation in the application of the best interest standard.[133] In addition, courts are currently taking different approaches in their application of this best interest standard, which inevitably leads to inconsistent results. To best demonstrate the inconsistency problems, it is helpful to compare the decisions in *Estate of C.W.* and *Johnson*, focusing specifically on each court's interpretation and analysis of one of the particular factors enumerated in *Terwilliger.* Close examination of the application of *Terwilliger* in these cases illustrates the malleability of the best interest standard as articulated and subsequently applied.

While the procedures may seem complex, they are minimally invasive. *See Estate of C.W.*, 640 A.2d at 439 ("The incision required is very small and post-operative discomfort is minimal. Most such procedures are done on an out-patient basis . . . . There is no significant risk of complications."). Most importantly, some of these "sterilization" procedures, such as the mini-laparoscopy, are no longer considered "permanent" methods of birth control. *Id.* ("In eighty percent of the cases, this form of tubal ligation is reversible. The tubes are simply rejoined in a relatively minor surgical procedure.").

129. Cleveland, *supra* note 76, at 141–42.

130. *In re* Terwilliger, 450 A.2d 1376, 1384 (Pa. Super. Ct. 1982).

131. *Id.*

132. Barton, *supra* note 74, at 1027.

133. *See id.* at 1027–28.

a. Weighing the Factors: *Estate of C.W.*

In *Estate of C.W.*, the court addressed the two questions that it deemed to be of greatest significance to the particular facts at issue. First, the court scrutinized the third factor enumerated in *Terwilliger*, the likelihood that C.W. would engage in sexual activity, either voluntary or involuntary. The court examined C.W.'s "behavior, her desire for physical contact, and an episode with an expert that revealed the potential for her victimization."[134] Given her history, the court felt that C.W. needed to be placed on some form of birth control.[135]

Next, continuing its reliance on *Terwilliger*, the court determined whether there were any less physically intrusive means of contraception available to her.[136] In order to make a proper determination, the court looked at various methods, including: barrier methods, such as an interuterine device (also known as an IUD) or diaphragm; hormonal treatments, such as Depro-Provera; the birth control pill; and sterilization methods, such as tubal ligations.[137] In order to determine the most appropriate method, the court considered both the level of physical intrusiveness and the practicality and effectiveness of a particular method.[138] After weighing the advantages and disadvantages of each method, the court found that the tubal ligation was the most appropriate means of contraception.[139]

The decision in *Estate of C.W.* sparked a great deal of debate. In fact, many critics point to this case to illustrate the pitfalls of the *Terwilliger* best interest standard. The court's ultimate decision, that sterilization was in the best interest of C.W., was based on the contention that "[w]hen the alternative medical procedures are weighed against tubal ligation, a relatively simple and extremely effective procedure, the latter emerges as the best option."[140] Writing for the dissent, Justice Johnson questioned the majority's application of the best interest test.[141] He argued that the "least restrictive means" test illustrates that "other contraceptives have been proven unworkable, and that the sterilization procedure is the least significant intrusion necessary to protect [C.W.'s] best interests."[142] The majority completely ignored the mandates of *Terwilliger* by weighing the pros and cons of various birth control methods in-

134. Cleveland, *supra* note 76, at 144.

135. Estate of C.W., 640 A.2d 427, 439 (Pa. Super. Ct. 1994).

136. *Id.* at 433–34.

137. *Id.* at 437–39.

138. *Id.* at 437.

139. *Id.* at 439 ("Anything short of tubal ligation requires experimenting with various contraceptive medications that may cause her to experience more seizures, more pain and discomfort. When the alternative medical procedures are weighed against tubal ligation, a relatively simple and extremely effective procedure, the latter emerges as the best option.").

140. *Id.* at 439.

141. *Id.* at 441 (Johnson, J., dissenting).

142. Adler, *supra* note 44, at 1334–35 (citing *Estate of C.W.*, 640 A.2d at 439 (Johnson, J., dissenting)).

stead of finding by clear and convincing evidence that all other methods are unworkable given the facts and circumstances specific to C.W.[143] Other critics of this decision contend that state courts must expend more energy examining both present and plausible future contraceptives.[144]

Unfortunately, many of the mentally disabled individuals on whose behalf these petitions are filed may suffer from other medical conditions or are on some type of prescription medication. In such instances, many current forms of birth control may interfere with those medications or may cause the individual to endure a wide variety of side effects.[145] Exhausting all other forms of contraception, as Justice Johnson and other critics propose, may infringe on the mentally disabled individual's right to privacy to a greater degree than a simple sterilization procedure.[146] How far must courts go to determine whether there are less restrictive means available? Must courts subject mentally disabled individuals to every form of birth control available to see if it is appropriate?

b. Clear and Convincing Standard: *Johnson*

In *Johnson*, the Circuit Court of Cook County, Illinois, held that "[a]lthough the court feels a permanent form of birth control is in [the individual's] best interest[,] the wisdom of . . . *Terwilliger* . . . keeps [it] from concluding that a tubal ligation is the only form of birth control left to be considered."[147] Here, as in *Estate of C.W.*, the court also focused on the less physically intrusive means of contraception. During the course of the trial, many forms of birth control were discussed, including birth control pills, barrier methods, interuterine devices, and tubal ligations.[148] Ms. Johnson had been on Depro-Provera, but suffered greatly from numerous side effects such as hair loss and weight gain.[149] At the time of the trial, she was using the Ortho Evra patch, but both Ms. Johnson and her guardian reported problems with the patch staying in place.[150] In addition, there were concerns relating to the effectiveness of this method given that Ms. Johnson weighed more than 190 pounds.[151] The facts indi-

143. *Estate of C.W.*, 640 A.2d at 444–45 (Johnson, J., dissenting) ("*Terwilliger* prohibits this Court from affirming the trial court's grant of a petition for sterilization of an incompetent individual unless *all less drastic contraceptive methods are unworkable and* expert medical testimony has shown that *the sterilization procedure requested is the least significant intrusion necessary to protect the interests of the individual.* . . . Absent clear and convincing evidence that all other methods of contraception are unworkable for C.W., this Court cannot uphold the trial court's authorization of C.W.'s sterilization.").

144. Cepko, *supra* note 17, at 164.

145. *See* Adler, *supra* note 44, at 1367 ("The potential life-endangering risks facing both Catherine and her fetus, were she to become pregnant, necessarily place her right to procreate in a different light than that of a healthy woman who has no such risks.").

146. *See supra* note 128 and accompanying text.

147. Estate of Johnson, No. 96 P 11118, slip op. at 10 (Ill. Cir. Ct. Aug. 11, 2005) (citing *C.W.*, 640 A.2d at 439 (Johnson, J., dissenting)).

148. *Id.* at 8–11.

149. *Id.* at 8.

150. *Id.* at 9.

151. *Id.*

cated that Ms. Johnson had been exposed to a broad range of contraceptive options. Yet, instead of granting the petition for a tubal ligation, a minimally invasive procedure, the court ordered that she experiment with an interuterine device. If that method of contraception should prove unworkable, the court agreed to revisit the question of the tubal ligation in the future.[152]

It is difficult to discern whether *Estate of C.W.* or *Johnson* reached the proper result. In *Estate of C.W.*, the court rejected the interuterine device because of the risk of infection and the intrusiveness of the annual replacement procedure.[153] The court in *Johnson*, however, found that the interuterine device was most appropriate. If the facts and circumstances were decidedly different, one might be more willing to accept this discrepancy. Instead, these cases serve to illustrate both the inconsistency of the best interest standard as articulated in *Terwilliger* and subsequently applied, and the inconvenience of exposing mentally disabled women to every available method of contraception. Comparing the outcomes in *Estate of C.W.* and *Johnson*, one may argue that subjecting individuals to all of these alternatives is a greater restraint and infringement on the individual's right to privacy than the tubal ligation procedure itself, especially given that the procedure, as currently performed, is considered to be reversible.[154]

Currently, the best interest inquiry articulated in *Terwilliger* is the best approach available to courts in determining whether to grant petitions for sterilization. Unfortunately, as illustrated, this standard is susceptible to a great deal of judicial manipulation and error; it requires that courts consider upwards of nine factors but provides little, if any, guidance with respect to the weight of each. The *Terwilliger* best interest inquiry must be revised to better ensure consistent and proper results. The simplified standard proposed in the next section draws upon the merits of each of the three legal rules currently employed and aims to better protect the interests of the individual at issue.

IV. RESOLUTION: THE REVISED BEST INTEREST INQUIRY

While the legal rules currently applied to petitions for sterilization offer weak protection and yield inconsistent results, weighing a smaller number of factors will better respect the values placed on the fundamen-

152. *Id.* at 12.

153. Cleveland, *supra* note 76, at 144.

154. Given the advancements in contraception in just the past decade, there is a strong argument the analysis should be adjusted to account for the fact that these procedures are no longer permanent. When *Terwilliger* was decided, the proposed sterilization procedure was irreversible. In recent years, however, a reversible form of tubal ligation has been developed. In addition, other medical advances, including in vitro fertilization, allow women with severe damage to their fallopian tubes to conceive. *See* Estate of C.W., 640 A.2d 427, 439 n.13 (Pa. Super. Ct. 1994) (discussing these medical developments).

tal right to privacy and better protect the interests of those citizens not necessarily able to protect themselves. In *Terwilliger*, the Pennsylvania Superior Court properly granted courts greater discretion to determine whether sterilization was appropriate by setting forth a nonexclusive list of factors to consider.[155] Unfortunately, *Terwilliger* failed to provide adequate guidance to the lower courts with respect to the significance of those factors and improperly imposed a strong presumption against sterilization. The inquiry must be simplified to ensure that proper results are reached.[156] In the spirit of *Grady*, *Hayes*, and *Terwilliger*, the factors of the revised best interest inquiry proposed in this Part combine elements of the substituted judgment standard, the mandatory criteria rule, and the discretionary best interest standard. To determine whether the petition for sterilization is in the mentally disabled individual's best interest, the court must engage in a two-step process. First, the court must find, by clear, cogent, and convincing evidence, that the individual is incompetent and that contraception is required. Second, the court must consider: (1) the recommendation of the parents or guardians; (2) the availability of less intrusive alternative means of contraception; and (3) the physical and emotional trauma that would result if the individual were to become pregnant. By limiting the number of factors considered and encouraging courts to exercise discretion when balancing these factors, this standard will better ensure that the proper result is reached in light of the facts and circumstances of each individual case.

A. Required Factual Findings

In accordance with the opinions of most scholars and state courts, this revised best interest inquiry requires that two factual findings be made before the court further considers a petition for sterilization. First, the judge must find, by clear, cogent, and convincing evidence, that the individual lacks the competency required to make her own decision regarding sterilization.[157] The rationale behind this threshold requirement is self-evident—if the individual is competent to make the decision, then she is free to exercise her right to privacy without court interference.

Second, the judge must conclude that contraception is required. To do so, the judge must find that the individual is fertile and that the individual lacks (and will continue to lack) the mental capacity necessary to care for a child.[158] Some critics have argued that the judge should also consider whether the individual is currently engaged in sexual activity or is likely to engage in such behavior in the near future. However, this

155. *See* discussion *supra* Part III.C.1.

156. *Johnson*, No. 96 P 11118, slip op. at 10 ("Although the court feels a permanent form of birth control is in Kirsten Johnson's best interest the wisdom of the *Terwilliger* case keeps me from concluding that a tubal ligation is the only form of birth control left to be considered.").

157. *See In re* Hayes, 608 P.2d 635, 641 (Wash. 1980).

158. *Id.*

consideration ignores the valid concern of rape or sexual abuse. Thus, unlike the other legal rules currently applied, this proposed standard requires that courts find only that the individual is incapable of making her own decision regarding sterilization and that contraception is necessary before reviewing petitions for sterilization.

B. Level of Discretion Afforded to State Courts

Similar to the *Terwilliger* best interest standard, the revised best interest standard will afford judges considerable discretion. The goal of this standard is to ensure that judges are delving into the facts and circumstances specific to the individual, thereby assuring that *her* best interests are met and that the petition for sterilization is not denied on the grounds of a questionably significant fact, such as the uncertainty that the individual may understand her sexuality in the future. Although some may argue that the discretion of judges should be severely limited in order to protect against judicial manipulation,[159] it no longer follows that restricting judicial discretion ensures the proper result. Those in favor of limiting judicial discretion do not give enough credit to the strides that have been made to rid this country of the eugenics movement.[160] Though there is value in trying to correct the abuses of the past, such correction is no longer necessary in this context.

C. Factors of the Revised Best Interest Inquiry

As previously stated, the revised best interest inquiry requires that courts weigh the following factors: (1) the recommendation of the parents or guardians; (2) the availability of less intrusive alternative means of contraception; and (3) the physical and emotional trauma that would result if the individual were to become pregnant. Each factor serves to protect the well-being of the individual. Examining the good faith of the petitioner quells any residual concerns related to abuses of the past and ensures that court authorization is sought with the best interest of the disabled person in mind rather than the petitioner's or the public's convenience. Consideration of alternative means of contraception and of the potential physical and emotional trauma associated with pregnancy best guarantees that the court will carefully scrutinize the facts and circumstances specific to the individual on whose behalf the sterilization is sought.

159. *See* discussion *supra* Part III.B.

160. Conscious of the desire to correct such abuses, the *Johnson* court entered a pretrial motion in limine, forbidding the use of sterilization in order to remove "any political overtones of governmental-sponsored sterilization." *Johnson*, No. 96 P 11118, slip op. at 6.

1. Factor One: Recommendations of the Parents or Guardians

Courts must weigh the recommendations of the parents or guardians of the mentally disabled adult. The purpose of sterilization law is to promote decisions that best reflect the interests of the mentally incompetent individual at issue.[161] Granting weight to these opinions encourages courts and parents or guardians to work together to determine what is actually in the individual's best interest. Critics may argue that such considerations are of little, if any, value because surrogate decision makers do not know what choice the disabled person would make if competent to do so and are likely to interject their own values or preferences.[162] However, such arguments discount the fact that parents and guardians have been entrusted with the care of the mentally disabled individual. In addition, unlike the substituted judgment standard, the court is only taking into account the parent's or guardian's recommendation and not basing its decision entirely on their testimony. Provided that they are petitioning the court for the "right" reasons (namely, for the best interest of the mentally incompetent individual), their input is of great significance and is, at the very least, worthy of consideration.[163]

2. Factor Two: Alternative Means of Contraception

As evidenced in Part III of this note, decisions to grant or deny petitions for sterilization often turn on a determination of whether less intrusive means of contraception are available. Under this revised best interest inquiry, courts will be instructed to weigh the costs and benefits of alternative methods of birth control. The decision to follow the court's rationale in *Estate of C.W.*, rather than *Johnson*, is motivated by numerous concerns. First, subjecting a mentally incompetent individual to various hormonal treatments with many potential side effects is more intrusive than a simple, and now reversible, tubal ligation. Second, refusing to authorize a tubal ligation on the grounds that such an order would infringe on the individual's fundamental right to privacy and then ultimately ordering that the same individual utilize a less permanent form of contraception is contradictory. Other methods of contraception, while not necessarily permanent, infringe on that right in the exact same way—by preventing the individual from procreating. Finally, arguing that courts may grant petitions for sterilization only "when other contraceptives have been proven unworkable"[164] is unrealistic. If "unworkable" is

161. Scott, *supra* note 35, at 847.

162. Cantor, *supra* note 89, at 197; *see also* discussion *supra* Part III.A.

163. *See* Scott, *supra* note 35, at 847 ("[T]he interests of the mentally retarded person will be best protected by a legal rule that . . . supports private decision making by the individual or, if she is incompetent to make the reproductive decision, by her parents.").

164. Adler, *supra* note 44, at 1334–35 (citing Estate of C.W., 640 A.2d 427, 441 (Pa. Super. Ct. 1994) (Johnson, J., dissenting)).

analogous to "failed," then the entire inquiry falls apart—if a method of contraception fails, then that suggests that the individual has become pregnant. Thus, by weighing the merits and demerits of each method of birth control, taking into account other prescription medications the individual may be required to take and side effects the individual may have to endure, the individual's interest will be better protected and she will not have to endure the tribulations of experimenting with every method of contraception available.

3. Factor Three: Potential Trauma of Pregnancy

The third and final factor that should be considered is the emotional and physical trauma that the individual would endure if she became pregnant. Again, the focus of this inquiry is to ensure that the petition is granted or denied on the basis of the best interests of the mentally disabled individual. To assess potential trauma, the court must examine the current health of the mentally disabled individual. Specifically, courts should take into account the various medications that the mentally disabled individual might be taking and the consequences of discontinuing use of such medication if pregnancy occurred. In *Johnson*, for example, Ms. Johnson was taking a number of prescriptions to cope with anxiety and depression. If she were to become pregnant, she would have to discontinue use of all of these medications and, as a result, her own mental health would suffer. In addition, the court should consider the potential emotional trauma the individual would suffer if after carrying the baby to term, she lost custody of the child, either voluntarily or otherwise. The individual's ability to cope with the emotional ramifications of pregnancy and labor must not be ignored.

Although some may argue that this factor-based inquiry is still susceptible to judicial manipulation, it is clear that this standard narrows the court's focus on the individual to ensure that it is making a decision that is actually in her best interest. If this standard had been applied in *Estate of C.W.* and *Johnson*, the outcomes would have likely been different. At the very least, the circumstances distinguishing the two decisions would have been more clear because the court opinions would reflect their focus on the interest of the individual, rather than on the proper application of *Terwilliger.*

V. CONCLUSION

On August 11, 2005, the Probate Division of the Circuit Court of Cook County ordered that Kirsten Johnson meet with a board certified gynecologist regarding the appropriateness of an interuterine device. Although the court respected the nine factor test enumerated in *Terwilliger*,

it explicitly stated that *Terwilliger* prevented it from making the decision that it truly believed was in Ms. Johnson's interest.[165] The *Johnson* decision proves that the *Terwilliger* standard is so complicated and difficult to satisfy that strict adherence to it may ultimately protect the right to procreate at the expense of the individual's best interest.

This note demonstrates that the legal rules currently employed should be abandoned for a revised best interest inquiry that moves beyond the abuses of the past and better respects the physical and mental well-being of the mentally disabled individual and the scope of the individual's fundamental right to privacy. Considering the parent's or guardian's perspective, weighing the advantages and disadvantages of alternative methods of contraception, and assessing the potential physical and mental trauma of pregnancy, will allow the court to make a more accurate case-by-case determination of an individual's best interest.

165. *Johnson*, No. 96 P 11118, slip op. at 10 (citing *C.W.*, 640 A.2d at 439 (Johnson, J., dissenting)).